Health Care Planning and Accountability Advisory Council

Monday, December 10, 2012 2:00 p.m.

Department of Health, Department Operations Center

Co-chairmen: Steven Costantino, Secretary, Executive Office of Health & Human Services; Christopher Koller, Commissioner, Office of the Health Insurance Commissioner

Attendees: Peter Andruszkiewicz; Timothy Babineau, MD; Kenneth Belcher; Jodi Bourque, Esq.; Al Charbonneau; Michael Fine, MD; Patricia Flanagan, MD; Herbert Gray; Jane Hayward; Dennis Keefe; Eve Keenan, Ed.D, RN; Dale Klaztker, Ph.D.; Edward Quinlan; and Fox Wetle, Ph.D.

Absentees: Alyn Adrain, MD; Douglas Bennett; Nicki Cicogna; Beth Cotter; Stephen Farrell; Marie Ganim, Ph.D.; Robert Hartman; Gloria Hincapie; George Nee; Donna Policastro, RNP; Sandra Powell; Mark Reynolds; and Louis Rice, MD

Staff in attendance: Melinda Thomas, Senior Policy Advisor, Executive Office of Health & Human Services; Michael Dexter, Chief, Office of Health Systems Development, Department of Health; Kim Paull, Director of Analytics, Office of the Health Insurance Commissioner; Elizabeth Shelov, Chief, Family Health Systems, Executive Office of Health & Human Services

Introduction

The Council meeting was convened promptly at 2:00 pm by Co-chairman Steven Costantino. Secretary Costantino welcomed the group and began with a review of the November 5, 2012 meeting minutes. He asked for any corrections or additions. Dr. Wetle submitted a hand-written set of minor edits and questions for staff to include in these minutes. There were no additional corrections or additions to the November 5, 2012 meeting minutes.

The purpose of today's meeting is to have a presentation on primary care in Rhode Island by The Graham Center of Washington, DC. The State of Rhode Island has a contract with The Graham Center under RFP #7449315.

The Robert Graham Center Presentation

Andrew Bazemore, MD, MPH, Director of The Robert Graham Center in Washington, DC, began the presentation at 2:10 pm with an overview of The Robert Graham Center and its work.[1] (Presentation was via speaker phone). Dr. Bazemore's co-presenter was Stephen Petterson, Ph.D., Director of Research at the Graham Center.

Why Study Primary Care? Researcher Barbara Starfield has found that health care systems built around primary care have lower costs, higher quality, and broader access.

Today's presentation relates to the delivery of primary care in Rhode Island and includes a small area-level analysis on the primary care workforce in Rhode Island. Along with The Lewin Group,

[1] Drs. Andrew Bazemore and Stephen Petterson were scheduled to attend the Council meeting in person to present their preliminary findings. Bad weather resulted in their flight being cancelled.

Graham is working to describe the effect of primary care supply on long term bed need in Rhode Island.

Social Deprivation and Health Needs: Graham reviewed the literature on social deprivation in great detail to understand its meaning for population health. The Center has developed a social deprivation index (SDI) that is based upon factors such as unemployment, poverty, crowding, low birth weight, single parent families, and less than 12 years of schooling. The SDI considers multiple geographies, poverty, and other factors that are used to predict need for health care services. Graham utilized Zip Code Tabulation Areas (ZCTAs) as a key geographical area for analyzing health utilization measures. ZCTAs are not a perfect measure, but it was the best, in Graham's judgment, for the current analysis. On SDI measures, Rhode Island fares slightly worse than its New England neighbors; compared to the nation, it fares a bit better.

Mr. Keefe: On Slide 11, how did you derive infant mortality? *Dr. Petterson:* From an area resource file across 3-5 years. *Mr. Keefe:* Is the rate restricted to Rhode Island residents? *Dr. Petterson*: As the data are from "Kidsnet", he believes that the measure exclusively includes Rhode Island residents.

Provider Workforce Characteristics and Comparisons: Graham reviewed the U.S. primary care workforce by provider type. There are just about 300,000 primary care providers in the U.S. This number includes physicians, nurse practitioners, and physician assistants. If you look at the geographical distribution, you will see a cluster of primary care providers in urban areas. Of all providers in large rural areas, the largest provider group is family physicians/general practitioners.

How do the data reflect physicians who work less than full-time? The masterfile of downloaded data does not reflect the number of hours worked. This is a real limitation (the data do not represent a total "body count.")

Dr. Fine indicated that "domains of practice" data will become more robust in Rhode Island as licensure data continue to be collected and refined.

Slide #18 Physicians/100K Population: Rhode Island has a high concentration of primary care physicians (Rate of 80.2 primary care providers, for a state rank of 8). Practice size: Rhode Island has a number of smaller primary care practices, which is not uncommon in New England. About thirty percent (30%) of all practices are 26 members (or greater) in size.

Slide #22 Logistical Regression Analysis: There is an inverse relationship between hospitalizations and primary care density.

Slide #24 Distribution of Health Clinicians: *Mr. Belcher*: Do the empty gray boxes indicate there are no providers in these areas of the state? *Dr. Petterson:* No. For some providers, there is confusion with addresses. This is one problem with granular data.

Secretary Costantino: Is the location of the providers correlated with the location of Rhode Island's hospitals? Are there really 37 physicians in West Greenwich? *Dr. Petterson:* There can be some confusion with home and work addresses and with mislabeling of data. Some townships have small populations. And keep in mind that we are looking at a rate, not a count. Exact counts are provided in the preliminary draft report that was distributed in advance of the meeting.

Slide #25 Primary care provider-to-population rates: West Greenwich and New Shoreham have higher rates than the statewide average. What is the value of this slide? *Dr. Fine:* There is a desperate need for a refined, statewide health work force data set. We need data that give us a better understanding of the small area workforce. Where can we do small area testing? Data that link primary care supply are expressed in rates, not counts.

Slide #27 Projecting primary care physician need: Nationally, there are about 300,000 primary care providers. What are the driving forces in projecting future need? The majority of the need for primary care physicians is driven by population growth and aging; a smaller factor is insurance expansion under the Affordable Care Act.

Rhode Island has experienced lower than average population growth and lower uninsurance rates. Through 2025, Graham does not see a considerable rise in the baseline projected need for primary care physicians in Rhode Island.

New Models and Potential Impact

Mr. Keefe: What impact has the economy had on utilization? Does utilization of health care services during an economic downturn impact primary care? There has been less of an impact on primary care than on specialty services. The emergency department has not experienced a downturn; there has been a flatness in ambulatory utilization. The economic climate is unpredictable, so it is hard to predict utilization going forward.

Questions:

Ms. Hayward: What are the projections for utilization of nurse practitioners and physician assistants in primary care going forward? Refer to slide #21 on PA/ NP participation in primary care. You can see real changes in the use of RNPs in economic models over time. If you change state laws to expand scopes of practice, you can further change the primary care delivery model. It is hard to discern an optimal team structure; the ecologies of certain distributions of RNPs and primary care physicians can result in lower hospitalizations and lower costs.

Mr. Andruszkiewicz: What are the assumptions regarding hospital projections? Are you using past practice to predict the future? Will there be more business in the future? That is the question.

Dr. Keenan: We need a vision of how health care laws will change the way we work with patients. Will we have a greater connection with patients? What are our assumptions?

John Murphy, MD (public member): For general internists and others functioning as hospitalists, how are they reflected in the data? *Graham:* They are not counted as primary care providers. Graham discounted them as part of this group. *Dr. Murphy:* There are 150 hospitalists in Rhode Island. The discount that Graham used may not be significant enough for reflecting the current number of hospitalists.

Dr. Fine: We do not have real time Rhode Island workforce data. *Graham:* For hospitalists, we extrapolate from national data down to the local level for estimating the number in this work force component.

New Models and Potential Impact

Patient Centered Medical Home Concept (PCMH): This is a platform for primary care delivery. It includes integrated care for patients, decision-making on the patient's part, electronic health records, and telephonic communications. This is a 40-year old term developed by pediatricians.

Accountable Care Organizations (ACOs): This is a group of providers responsible for the health care of a group of people. There is an alignment of incentives and accountability of providers across the continuum of care. ACO/lessons from other countries: In Spain and in the United Kingdom, a primary care focus is associated with reduced disparities. There is a focus on primary care as a delivery priority based on geographical locations and distribution of services.

Hennepin County, MN Hennepin Health: Started January 1, 2012. This model has a comprehensive risk financing structure and partners with the health department and integrated clinics. This plan serves a Medicaid population. To share risk, they are creating integrated clinics (poly-clinics).

Oregon Health Reform: Oregon Health Board is implementing this model. Oregon is dividing the state into CCOs (comprehensive care organizations). It has implemented a governance model similar to primary care trusts. Some look like the community health centers in Rhode Island.

Conclusions for Rhode Island: We need data to monitor any of these systems.

Challenges of the newly insured: Supply is less of an issue in Rhode Island than in many states. Pent up demand will be an issue; major supply challenges will be a problem. Rhode Island faces demand increases (e.g., aging population and the Affordable Care Act). Social deprivation drives outcomes in Rhode Island more than delivery gaps.

Commissioner Koller: We have to take into account social disparities in Rhode Island. We also have to consider hospital investment, hospital payment issues; two hospitals are currently in receivership. The General Assembly wants guidance for the future. Hospitals are going bankrupt now and decisions have to be made.

Secretary Costantino: Slide #50: Is the example of North Carolina and its insurance experiment current? *Graham*: Five year results show Medicaid payment policies were changed, 14 districts were created, and new care models were created. But North Carolina never got providers engaged in the process. An IT structure had to be created.

Commissioner Koller: In the examples of Minnesota, Oregon, and North Carolina, how does each handle patient assignments to medical homes? Dr. Bazemore indicated that there is an assignment process in North Carolina, but will get back to us on this question.

Dr. Fine: Rhode Island is the first state in the nation with the most patient centered medical homes level three's: how does that impact our cost? Is this the right metric? National Committee for Quality Assurance (NCQA) levels 1, 2 and 3: does each have a different impact on cost, emergency department utilization etc.? We should see the highest scores with lowest costs.

Dr. Wetle: Is there adequacy in the number of providers? There is reporting from the field that patient demand is so great that practice enjoyment is gone. The other side represents that it is very difficult to get a primary care provider appointment in RI. It is really hard to get a visit. Something

is missing here: can we measure the status quo simply by reviewing the numbers? What is the ideal in terms of practice size? Data that we bring to this is questionable. We ought to be able to get to the questions intelligently. (Work force data are needed).

There is a small geography here and we need to look at communities. What is the average wait time for a new appointment? What is the average wait time for an emergency appointment?

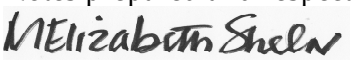
An extra open meeting will be held on Wednesday, December 19th from 12:30 pm - 2:30 pm in the Department of Health's Operations Center (lower level) to discuss the findings of the Hospital Conversions Act sub-group. Also, the Lewin Group will present its preliminary bed need model and provide an update on their recent stakeholder interviews. The next CON subgroup is scheduled for Monday December 17, 2012 at 10:00 am in Conference Room "C" at the Department of Administration in Providence.

Next Meeting

The next meeting of the Health Care Planning & Accountability Advisory Council is scheduled for: **Monday, January 14, 2013 at 2:00 p.m.** in Conference Room "A" at the Department of Administration, One Capitol Hill, Providence, Rhode Island.

With no further discussion, the meeting adjourned at 3:45 pm.

Notes prepared and respectfully submitted by:



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